Mountain View Hospital

Affiliate Location

Patient Name: _____ DOB: _____ Age: _____ Sex: _____

Location: Idaho Falls Arthritis Clinic Date: _____

Clinic Conditions of Admission to Mountain View Hospital Clinics

Medical And Surgical Consent: I, the undersigned, consent to the services which may be performed during this outpatient visit, including office visit, which may include but are not limited to laboratory procedures, radiology procedures, diagnostic procedures, stress testing, rendered to me under the general and special instructions of my provider. This consent includes testing for blood-borne infectious diseases, including but not limited to Hepatitis, Acquired Immune Deficiency Syndrome (AIDS), and Hum Immunodeficiency Virus (HIV), if a provider orders such tests for diagnostic purposes. If the patient takes any medications or other substances without orders from the provider, the patient hereby releases the hospital and provider from liability for any reaction that may occur. In the event of an emergency, **I authorize Mountain View Hospital (MVH) to transfer myself to another health care facility should my provider determine it necessary. In addition, I also consent to the release of my medical records to such facility.**

Release of Information: I authorize the clinic and any physician involved in my care to release medical information and supporting documentation of same as compiled in my medical records during the outpatient visit to any organization which is or may be liable or responsible for payment of charges associated with my care. If my injury is work-related, I authorize the clinic to release any information from my medical records to my employer and/or its designee. I acknowledge that data from my patient records will be accessible to all health care providers participating in my care or treatment, including but not limited to physicians, nurse and technicians at the hospital, home health agencies, ambulance companies, and such other health care agencies involved in my care. I acknowledge that patient medical records at the clinic are made available through computer networks to hospital personnel, providers involved in my care and their offices.

Patient Privacy: I have received and/or had the information sheet entitled “HIPAA NOTICE OF PRIVACY PARACTICES” available to me at www.mountainviewhospital.org

☐ **Acknowledged** I have received and/or had the opportunity to review MVH’s “Notice of Privacy Practices” either in electronic or paper form. Any questions that I had were answered.

Patient Rights: I understand that MVH has adopted an extensive patient rights policy, which affords patients’ rights to respect and foster the patient’s dignity, autonomy, positive self-regard, civil rights and involvement in their case. These rights are posted throughout our hospitals and clinics, available on our website, or available by asking the admissions desk for the Patients’ Rights pamphlet.

Weapons/Explosives/Drugs: I understand and agree that if the hospital at any time believes there may be a weapon, explosive device, or illegal substances or drug, or any alcoholic beverage in my room or in my belongings, the hospital may search my room and my belongings, confiscate any of the above items that are found, and dispose of them as appropriate, including delivery of any item to law enforcement authorities.

Financial Agreement and Assignment of Insurance Benefits: In consideration of clinic services rendered, I hereby authorize payment directly to the above named clinics for benefits otherwise payable

to me, but not exceed the clinics regular charges. In addition, I authorize payment of Medicare/Medicaid/Insurance benefits to any contracted provider; this includes, but is not limited to laboratory procedures, radiology procedures, and aesthesia pathology, or hospital services rendered to me under the general and special instructions of my provider during this encounter. I understand that I am financially responsible for charges. In the event that this account is not paid according to the terms of the clinics credit policy, I agree to pay interest at the rate of 18% APR and/or costs of collection agency or collection and suit is filed to recover payment, I agree to pay as a reasonable attorneys fee 33% of the principal and interest on my account balance, or any sums awarded by the court, whichever is greater, I further agree to pay reasonable cost to suit.

Medicare Patient Certification: I certify that the information given by me in applying for payment under Title XVII of Title XIX of the social security act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of the authorization to be used in place of the original and request payment of authorized benefits to be made on my behalf.

Mountain View Hospital is a Physician Owned Hospital: Upon request a list of ownership will be provided to you.

☐
Acknowledged

Legal Relationship between Hospital and Physician: I understand that all physicians furnishing services to me are independent contractors and are not employees or agents of the hospital. I am under the care and supervision of my attending physician and it is the responsibility of the clinic and its staff to carry out the instructions of my physician. It is my physician's responsibility to obtain my informed consent, when required, for medical or surgical treatment, special diagnostics or therapeutic procedure rendered to me. I understand that the hospital does bill for some professional fees are not included in the hospitals bill and will be billed separately by the physician/provider.

Notice Regarding Patient Protections against Surprise Billing: Upon request, an information sheet entitled "Your Rights and Protections against Surprise Medical Bills" will be provided to you. You may also obtain additional information at www.cms.gov/nosurprises.

☐
Acknowledged

Right to Receive a Good Faith Estimate of Expected Charges: Self pay patients have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services scheduled 3 days or more in advance of a procedure both verbally and in writing prior to services being rendered. You may also obtain additional information at www.cms.gov/nosurprises.

☐
Acknowledged

I hereby certify and state that I have read, and that I fully and completely understand the Conditions of Admissions and Authorizations for Medical Treatment, and that I have signed the Conditions of Admission and Authorization for Medical Treatment knowingly, freely, and voluntarily. Moreover, I certify and state that I have received no promises, assurance, or guarantees from anyone as to the result that may be obtained by any medical treatment or services.